MENTAL HEALTH SERVICES
OVERSIGHT AND ACCOUNTABILITY COMMISSION

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Evaluation of Shasta County MHSA Three Year Expenditure Plan

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The following identifies issues for potential oversight by the Commission, specific questions regarding Shasta County CSS plans to be addressed by the County or the Department of Mental Health, and comments intended to inform the continued work of the Commission, County and the Department of Mental Health.

Overview

Overall the County did an excellent job of involving community stakeholders in its planning process. Over 90 community stakeholders were identified as having taken part in some portion of the information gathering process and the Committee encourages Shasta County to continue its excellent partnering in this area. Shasta County sent out letters to the hosts of focus groups summarizing what was heard at each of these focus groups. The Committee thought this was an excellent way to insure stakeholder messages were heard and accurately recorded.

On page 13 of their plan, Shasta County describes how NAMI provided a daylong workshop to clients and family members regarding the Mental Health Services Act (MHSA). Again, the Committee felt this was most in keeping with the intent of the MHSA and commends Shasta County and NAMI for their investment in keeping consumers and family members involved in the transformation process. The decision to offer Client and Family operated services (p. 17) was an excellent response to feedback Shasta County received to its initial draft of its MHSA three year plan and the Committee encourages Shasta County to continue to embrace this level of responsiveness to community and stakeholder input. The Committee thought Shasta County showed significant sensitivity to the needs of its women consumers and women's issues overall (p. 27) and likewise with consumers who are parenting and related parenting issues.

This plan also shows Shasta County has a good understanding of partnership needs with Tribal Health Programs (p. 35). Overall, the analysis of service needs (p. 40-42) was a strength for Shasta County. The Committee would like to commend Shasta County for developing special Southeast Asian mental health clinics (p. 56)- an excellent strategy for meeting the needs of this special population. The Committee also appreciated the

excellent discussion of barriers contained on page 59 of the Plan. It is clear Shasta County intends to build on what it does well and we are anticipating positive results from this Plan.

The one shortcoming noted by the CSS committee concerns services for the GLBT population. On page 52 of their plan, Shasta County notes that "Gay, lesbian, bicultural, and transgender issues are virtually absent from public discussion in Shasta County." Shasta County states, "Full Service Partnership teams will be sensitive to the special needs of this population and will be supported and supervised to attend to these issues. Planning for future MHSA development will include more focus on this issue based on the experience of the Full Service Partnerships developed in the initial year**." The Committee is expecting and looking forward to the development of more specific interventions for this population, particularly given the level of need in Shasta County.**

Consumer and Family Involvement

Consumer and Family members were clearly participants in planning and there was outreach to non-traditional participants. The impact of this participation is evident in the plan in that the Client and Family Operated Services system development project is a direct result of the feedback received from consumers, family members and others. The Plan also references "continued two-way discussions" (p. 9) which is in keeping with MHSA goals for the on-going involvement of consumers and family members. One excellent example of this on-going dialogue is evidenced on page 112 in the Shasta plan in which the SHIFT-PLUS Leadership Council is discussed and clients and family members are specifically mentioned as participants on this council.

Fully Served, Underserved/Inappropriately Served, Un-served:

Shasta's discussion regarding its fully served, underserved/inappropriately served and unserved populations was excellent. The Committee would like to make special note of objectives outlined on page 45 of the Shasta Plan related to Response #4. We were pleased to see specific goals identified regarding improving penetration numbers for the Hispanic community and the Native American community.

Wellness/Recovery/Resilience:

Shasta County demonstrated an excellent understanding of these concepts in their plan. Awareness of wellness and recovery principles is evident in discussion on page 26 of the Shasta Plan regarding lost opportunities to support recovery and hope in transitional aged youth due to a lack of jobs, limited college availability, isolation, and systematic stigmatization in the press of mental health clients and services. Another example on page 31 states, "Research underscores our community findings, that it is critical during this transitional age to instill hope and promote resiliency in youth, especially in light of the limited opportunities in the county for achieving independence." Other wellness and recovery principles are evident on page 71 of the plan in discussion about the Clubhouse model, which requires that the program enable members to return to paid work through transitional, supported, or independent employment. The Committee was also able to see that cultural competency is an integral part of plans for developing wellness, recovery, and resiliency.

Education and Training and Workforce Development

The Mental Health Services Act speaks eloquently about the need for education and training in order to increase the supply of professional staff and other staff able to meet the needs of consumers and their families. In the MHSA, Section 8, Part 3.1 Education and Training Program, 5822 (f) it says "Curriculum to train and retrain staff to provide services in accordance with the provisions and principles of Parts 3, 3.2, 3.6, and 4." is required. Part 3 refers to training staff regarding the Purpose and Intent of the Mental Health Services Act. Part 3.2 refers to training staff regarding the purposes of innovative programs (to increase access to underserved groups, to increase the quality of services, including better outcomes, to promote interagency collaboration, and to increase access to services). Part 3.6 refers to training staff regarding the appropriate components of prevention and early intervention programs. The Committee feels this training is an essential part of helping staff to be full partners in transforming the mental health delivery system for all. Shasta County has made a significant commitment to training staff and on page 146 indicates $20,000 has been set aside to facilitate training staff in recovery and wellness principles.

Regarding workforce development, Shasta County is to be commended for its outreach to Chico State as a strategy for diversifying its workforce.

Collaboration

This is clearly one of Shasta County's strengths. The Committee noted that Shasta Mental Health Rural Initiative, which involves collaboration with community health care clinics, as an excellent strategy. The list of collaborative partners on page 133 of the Shasta Plan who have a demonstrated interest in working with the county on meeting the needs of Older Adults was equally impressive. SHIFT-PLUS, as described on page 88 of the plan also makes excellent use of strong collaborative relationships. The robust collaborative process in Shasta County enables them to talk about leveraging dollars in creative ways, for example with Catholic Charities and the City of Redding around housing issues. This impressed the Committee.

Programs: FSPs

SHIFT-PLUS Described as a recovery based full service partnership, SHIFT Plus is an enrollee-based, "whatever it takes" service model designed to provide access to housing, employment or employment preparation, medication, transportation, peer relations, social activities and education for individuals of all age groups. The Committee felt Shasta County was really stretching to do what it could in this area and wants to compliment Shasta for the work of the Employment Committee (p. 87) and for its excellent collaboration with partners described on pages 88-89 of the Shasta Plan.

Shasta Rural Mental Health Initiative Described as a recovery based full service partnership arrangement with rural community health clinics, including Indian Health Clinics, to provide integrated primary health care and mental health to priority populations. Services include telepsychiatry, intensive case management, and crisis and support services. This strategy is designed to serve all age groups. The Committee feels this is an excellent strategy and wishes to commend Shasta County for its excellent collaboration and for its plans to convene the Shasta Rural Health Initiative Leadership Council. The composition of this council and the work it will undertake

will stand as a model for others of how a truly transformational process is achieved. Interagency Older Adult Services Program Described as a system of interagency services for adults 60 years and older, the program description on page 128 of the Shasta Plan outlines how the program will collaborate with multiple agencies and conduct intensive resource and program development in order to identify collaborative resources and outreach and engagement strategies. It has already been mentioned elsewhere how Shasta County has made excellent use of partnering with its community stakeholders.

System Development

Client and Family Operated Services This system development project is an excellent strategy consistent with the goals of the MHSA. The program description on page 67 states the program will support recovery and wellness in existing SCMH programs as well as MHSA full service partnership programs**. The Committee is looking forward to future reports about this program.**

Outreach and Engagement programs

Interagency Older Adult Services Program This looks like an excellent outreach and engagement program. **One question: Are the Personal Services Coordinators paid positions?**

CONCLUSION

Question: The overarching question for the Oversight and Accountability Commission is: "How will the three-year CSS plan move your county system forward to meet the standard of comprehensive, timely, appropriate services in the Mental Health Services Act**?" The Commission asks that the county prepare to answer this question as the first year of CSS plans are implemented.**

The Commission recognizes the need to build a more reliable baseline of information available to everyone, so that answers can be understood within a context. To do so, the Commission is seeking to develop a description of the mental health system in your county, and in all counties, including an explanation of the structure of the service delivery system, access policies for all children and adults, and range of services received by those not in a categorical funded program.

The Commission is working to develop a baseline to assess the gaps between existing standards of care in mental health and the comprehensive, integrated services envisioned by the Mental Health Services Act. Statewide and national reports tell us that services have been limited and effectively rationed because funding is not tied to caseloads. The Commission believes it will be advantageous to all of the individuals and the private and public organizations involved in change, and beneficial to the public, to have a realistic understanding of the challenges to transforming the mental health system.

In the coming year, the Commission will seek information such as the average caseloads for personal service coordinators and/or case managers and for psychiatrists for the largest percentage of people served. We would like to know what percentage of all mental health consumers are receiving or have access to comprehensive, appropriate, and integrated services, such as individual or group therapy, family counseling, routine medical and dental care, educational or vocational training, substance abuse treatment, supportive housing, and other recovery-oriented services.

To begin with, the Commission will compile available data from traditional sources, and utilize the information you have provided in the CSS plan. In this first year of implementation, we will be enlisting your assistance in measuring the magnitude of changes taking place now and the prospective changes for many years to come. The Commission also will be asking you to determine and report on what resources are lacking in your county. The CSS Committee recognizes the tremendous effort involved in the planning process and commends the county on its many successes.